AMENDED IN ASSEMBLY JULY 2, 2003

AMENDED IN SENATE JUNE 3, 2003

AMENDED IN SENATE MAY 12, 2003

AMENDED IN SENATE MARCH 24, 2003

SENATE BILL No. 354

Introduced by Senator Speier

February 19, 2003

~~An act to amend Sections 1871.4, 11760, and 11880 of, and to add Section 11661.8 to, the Insurance Code, and to amend Section 139.3 of, and to add Section 4600.2 to, the Labor Code, relating to workers'~~ *An act to amend Section 11760 of, and to add Section 11661.8 to, the Insurance Code, and to amend Sections 138.6, 139.3, 4062, 4903, 5304, 5502, 5502.5, and 5703 of, to add Sections 4610, 4611, and 5814.3 to, to add Article 2.3 (commencing with Section 4615) to Chapter 2 of Part 2 of Division 4 of, to add and repeal Section 4612 of, to repeal Sections 4614 and 4614.1 of, and to repeal and add Section 4604 of, the Labor Code, relating to workers'* compensation insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 354, as amended, Speier. Workers' compensation ~~insurance: fraud: limits~~.

~~Existing~~

(1) Existing law provides that it is unlawful to knowingly make specified false or fraudulent statements in connection with obtaining compensation under or reducing the premium or cost of a workers' compensation insurance policy. Existing law specifies a maximum fine of $50,000 for a violation of these provisions.

This bill would raise the maximum fine for a violation of these provisions to $100,000.

~~Existing law generally regulates the terms of workers' compensation insurance policies. Existing law requires an employer to provide specified medical services that are reasonably required to cure or relieve an injury suffered by an employee in the course of employment.~~

~~This bill would preclude an insurer from insuring an employer for more than 15 one-hour visits to a chiropractor by an employee in connection with any claim made under the policy, unless the employee has obtained the approval of a physician for additional visits. The bill would provide that an insured employer is not required to provide, and is not liable for, more than 15 of these visits without physician approval.~~

~~Existing~~

(2) Existing law prohibits a physician from referring a person for specified goods or services if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral. A violation of this provision is a crime.

This bill would add referrals for services provided by outpatient surgical centers, as defined, to the referrals subject to this prohibition. By changing the definition of a crime, this bill would impose a state-mandated local program.

~~The~~

(3) Existing law requires the Administrative Director of the Division of Workers' Compensation, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, to develop a cost-efficient workers' compensation information system.

This bill would require the administrative director, by interagency agreement or by contract, to develop and maintain a system, using workers' compensation system data, for the purpose of monitoring and improving the quality and cost-effectiveness of health care services delivered to injured workers, and to report to the Legislature by July 1, 2004, on the plan for implementation and status of this system. It would also require the administrative director and the Commission on Health and Safety and Workers' Compensation, until the system is implemented, to conduct a review of certain data submitted by the State Compensation Insurance Fund and to report their findings and recommendations to the Legislature.

(4) Existing law establishes procedures with respect to disputes between employers and employees regarding the compensability of the injury and the extent and scope of medical treatment for that injury.

This bill, on and after July 1, 2004, would establish an independent medical review and appeal processes for purposes of resolving disputed medical treatment services, as defined, and would make conforming changes. The bill would require the Division of Workers' Compensation, by March 1, 2004, to contract with one or more independent medical review organizations to conduct these independent medical reviews, and would specify procedures relating to hearings, continuances, and receipt of evidence in connection with these independent medical reviews. Failure by an employer to implement decisions pursuant to the independent medical review would subject the employer to an administrative penalty of not more than $5,000.

(5) Existing law generally regulates the terms of workers' compensation insurance policies.

This bill, on and after February 1, 2004, would prohibit an employee, until the division enters into the above contract with independent medical review organizations, from obtaining more than 15 one-hour visits to a chiropractor or physical therapist in connection with any work-related injury, unless the employee has obtained the approval of the insurer or self-insured employer or there has been an independent medical review conducted by the Department of Managed Health Care.

This bill would require every employer to establish a utilization review process, either directly or through its insurer or entity with which an employer or insurer contracts for these services, in accordance with specified criteria, and would authorize the administrative director to assess administrative penalties for failure to meet certain requirements. It would also require every employer, insurer, or entity with which an employer contracts for utilization review services to establish and maintain a utilization review appeals process by which employees may appeal any authorization of medical treatment based upon medical necessity in an admitted claim.

(6) Existing law limits the amount of fees payable to medical providers under contracts with the employee's health benefit program for health care services rendered to employees.

This bill would repeal those provisions. The bill would also authorize the establishment of a 6-year pilot project whereby an employer may contract with a health care organization to be the exclusive provider of

all health coverage for occupational and nonoccupational injuries and illness incurred by its employees, and would specify the coverages to be provided by participating health care organizations.

(7) Existing law authorizes the Workers' Compensation Appeals Board to determine, and allow as liens against any sum to be paid as compensation, certain specified amounts for various expenses.

This bill would prohibit any lien against any sum paid as compensation, on and after July 1, 2004, from being allowed by the appeals board if certain conditions exist relating to the utilization review process or independent medical review process.

(8) Existing law provides that when payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 10%.

This bill would specify that the above provision would not apply to payments for medical treatment that are subject to utilization review or independent medical review when the medical treatment is appealed by an insurer to the appeals board and the appeals board upholds the appeal. It would provide that in such a case, the appeals board may order the insurer to take specified actions in connection with the order of the appeals board, and would authorize the division to impose penalties on an insurer for nonconformance with the order.

(9) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. Section 1871.4 of the Insurance Code is~~

SECTION 1. Section 11661.8 is added to the Insurance Code, to read:

11661.8. (a) Until the Division of Workers' Compensation enters into a contract to administer the independent medical review process as required by subdivision (a) of Section 4616 of the Labor Code, and commencing February 1, 2004, an employee may

not obtain more than 15 one-hour visits to a chiropractor or physical therapist in connection with any work-related injury, unless the employee has obtained the approval of an insurer or self-insured employer or there has been an independent medical review determination. An independent medical review determination shall be conducted at the expense of the insurer or self-insured employer. The division shall authorize the independent medical review in the absence of the utilization review and appeal set forth in Sections 4610 and 4611, and the independent medical review shall be forwarded by the division to the Department of Managed Health Care for purposes of obtaining a review. The division shall enter into any agreements with the Department of Managed Health Care necessary to implement this subdivision. An independent medical review granted pursuant to this section shall have the same presumption and may be appealed to the appeals board as otherwise set forth in Section 4618 and Section 4903, and all penalties set forth in 5814.3 shall apply.

(b) This section shall be operative only until the Administrative Director of the Division of Workers' Compensation files a declaration with the Secretary of State indicating that the division has entered into a contract to administer the independent medical review process required in subdivision (a) of Section 4616 of the Labor Code, at which time this section shall become inoperative.

SEC. 2. Section 11760 of the Insurance Code is amended to read:

11760. (a) It is unlawful to make or cause to be made any knowingly false or fraudulent statement, whether made orally or in writing, of any fact material to the determination of the premium, rate, or cost of any policy of workers' compensation insurance, for the purpose of reducing the premium, rate, or cost of the insurance. Any person convicted of violating this subdivision shall be punished by imprisonment in the county jail for one year, or in the state prison for two, three, or five years, or by a fine not exceeding ~~fifty~~ *one hundred* thousand dollars ~~($50,000)~~ *($100,000)*, or double the value of the fraud, whichever is greater, or by both imprisonment and fine.

(b) Any person who violates subdivision (a) and who has a prior felony conviction of the offense set forth in that subdivision shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (a). The existence

of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

SEC. 3. Section 138.6 of the Labor Code is amended to read:

138.6. (a) The administrative director, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, shall develop a cost-efficient workers' compensation information system, which shall be administered by the division. The administrative director shall adopt regulations specifying the data elements to be collected by electronic data interchange.

(b) The information system shall do the following:

(1) Assist the department to manage the workers' compensation system in an effective and efficient manner.

(2) Facilitate the evaluation of the efficiency and effectiveness of the benefit delivery system.

(3) Assist in measuring how adequately the system indemnifies injured workers and their dependents.

(4) Provide statistical data for research into specific aspects of the workers' compensation program.

(c) The data collected electronically shall be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. The administrative director may adopt regulations authorizing the use of other nationally recognized data transmission formats in addition to those set forth in the Electronic Data Interchange System for the transmission of data required pursuant to this section. The administrative director shall accept data transmissions in any authorized format. If the administrative director determines that any authorized data transmission format is not in general use by claims administrators, conflicts with the requirements of state or federal law, or is obsolete, the administrative director may adopt regulations eliminating that data transmission format from those authorized pursuant to this subdivision.

(d) (1) The administrative director shall directly, by interagency agreement or by contract, to the extent permitted by

state law, develop and maintain a system, using workers' compensation information system data, for the purpose of monitoring and improving the quality and cost-effectiveness of health care services delivered to injured workers. The system shall include, but not be limited to, data permitting health care fraud detection, analysis of the payments and costs of health care services, treatment patterns and outliers, and evaluation of worker health and employment outcomes. Except in cases of health care fraud, the workers' compensation information system shall contain safeguards to protect the confidentiality and privacy of the data contained in the system, including the use of encryption and other methods to protect individually identifiable information.

(2) The administrative director shall report to the Legislature by July 1, 2004, on the plan for implementation and status of this system, including the projected timeframe and costs for implementation.

(e) On an interim basis, until the system set forth in subdivision (d) is implemented, the State Compensation Insurance Fund shall submit to the administrative director the identical data submitted by the State Compensation Insurance Fund to the California Workers' Compensation Institute database. The administrative director and the Commission on Health Safety and Workers' Compensation shall conduct a review of the data submitted by the State Compensation Insurance Fund for the purposes set forth in subdivision (d) and report their findings and recommendations to the Legislature.

SEC. 4. Section 139.3 of the Labor Code is amended to read:

139.3. (a) Notwithstanding any other provision of law, to the extent those services are paid pursuant to Division 4 (commencing with Section 3200), it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, *outpatient surgical center,* or diagnostic imaging goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 139.31, the following shall apply:

(1) ‘‘Diagnostic imaging’’ includes, but is not limited to, all X-ray, computed axial tomography magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) ‘‘Immediate family’’ includes the spouse and children of the physician, the parents of the physician, and the spouses of the children of the physician.

(3) ‘‘Physician’’ means a physician as defined in Section 3209.3.

(4) A ‘‘financial interest’’ includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the physician refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect relationship between a physician and the referral recipient, including, but not limited to, an arrangement whereby a physician has an ownership interest in any entity that leases property to the referral recipient. Any financial interest transferred by a physician to, or otherwise established in, any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the physician.

(5) A ‘‘physician’s office’’ is either of the following:

(A) An office of a physician in solo practice.

(B) An office in which the services or goods are personally provided by the physician or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when that licensure or certification is required by law.

(6) The ‘‘office of a group practice’’ is an office or offices in which two or more physicians are legally organized as a partnership, professional corporation, or not-for-profit corporation licensed according to subdivision (a) of Section 1204 of the Health and Safety Code for which all of the following are applicable:

(A) Each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or

treatment, through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, and except that in the case of multispecialty clinics, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(7) "Outpatient surgical center" means a surgical clinic, as defined in paragraph (1) of subdivision (b) of Section 1204 of the Health and Safety Code, when the clinic renders services that are paid for pursuant to Division 4 (commencing with Section 3200).

(c) (1) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(2) It shall be unlawful for a physician to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation.

(d) No claim for payment shall be presented by an entity to any individual, third-party payor, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) A physician who refers to or seeks consultation from an organization in which the physician has a financial interest shall disclose this interest to the patient or if the patient is a minor, to the patient's parents or legal guardian in writing at the time of the referral.

(f) No insurer, self-insurer, or other payor shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(g) A violation of subdivision (a) shall be a misdemeanor. The appropriate licensing board shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), (e), or (f) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.

SEC. 5. Section 4062 of the Labor Code is amended to read:

4062. (a) *This section shall not apply to disputes concerning the extent and scope of medical treatment subject to the independent medical review process set forth in Article 2.3 (commencing with Section 4615) of Chapter 2 of Part 2.*

(b) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, ~~the extent and scope of medical treatment,~~ the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting

party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.

~~(b)~~

(c) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.

~~(c)~~

(d) Upon completing a determination of the disputed medical issue, the physician selected under subdivision ~~(a) or~~ (b) *or (c)* to perform the medical evaluation shall summarize the medical findings on a form prescribed by the Industrial Medical Council and shall serve the formal medical evaluation and the summary form on the employee, employer, and administrative director. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

~~(d)~~

(e) No disputed medical issue specified in subdivision ~~(a)~~ *(b)* may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

~~(c)~~

(f) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision ~~(a)~~ *(b)* shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision ~~(a)~~ *(b)*. Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.

SEC. 6. Section 4604 of the Labor Code is repealed.

~~4604. Controversies between employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either party.~~

SEC. 7. Section 4604 is added to the Labor Code, to read:

4604. Controversies, other than those subject to the independent medical review process, arising between employer and employee under this chapter shall be determined by the appeals board upon the request of either party. With respect to disputes subject to the independent medical review process, the jurisdiction of the appeals board shall be exercised in a manner consistent with Section 4618.

SEC. 8. Section 4610 is added to the Labor Code, to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity of proposed medical treatment services are consistent with criteria or guidelines that are supported by clinical principles and processes. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the medical treatment services requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with sound clinical principles and processes, including the guidelines as set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be

communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary, and an insurer or self-insured employer shall only be liable for those services determined medically necessary. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary, the dispute shall be resolved, except upon compromise between the parties, by submitting the dispute to an independent medical review as set forth in Article 2.3 (commencing with Section 4615), and an appeal of the independent medical review determination shall be offered to all parties as set forth in Section 4618. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include both of the following:

(A) A clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines

used, and the clinical reasons for the decisions regarding medical necessity.

(B) Information regarding the right to file an appeal pursuant to Section 4611 and the right to independent medical review pursuant to Article 2.3 (commencing with Section 4615).

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administrative Revolving Fund.

SEC. 9. Section 4611 is added to the Labor Code, to read:

4611. (a) Every employer, insurer, or entity with which an employer contracts for utilization review services, as defined in

Section 4610, shall establish and maintain a utilization review appeals process that shall be the exclusive process by which employees may appeal any modification, delay, or denial of a request for authorization of medical treatment based upon medical necessity in an admitted claim. The administrative director shall adopt regulations specifying the appeals process requirements.

(b) The employer, insurer, or other entity subject to this section shall provide the employee with a written statement on the disposition of the appeal no later than five working days after receipt of the appeal or, in cases requiring expedited review pursuant to paragraph (2) of subdivision (g) of Section 4610, no later than 72 hours after receipt of the appeal. Written responses to appeals shall describe the criteria used and the clinical reasons for the decision, including all criteria and clinical reasons related to medical necessity.

(c) A physician or a designee of the employee may join with or otherwise assist the employee in the appeal.

(d) The employer, insurer, or other entity subject to this section shall keep in its files all copies of appeals, and the responses thereto, for a period of five years, and make these files available to the administrative director on request.

(e) No person other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the medical treatment services appealed from the utilization review determination set forth in Section 4610 may deny, delay, or modify requests for authorization of medical treatment for reasons of medical necessity. When a decision to modify, delay, or deny a request for authorization of medical treatment is upheld through the utilization review appeals process, the written notice of the appeals determination shall include notice of the employee rights pursuant to Section 4615. The utilization review appeals process record shall be admissible before the appeals board in appeals authorized pursuant to Section 4618. No later than five working days after submission of an appeal or after an appeal decision upholds a modification, delay, or denial of a request for authorization of medical treatment, or earlier in cases requiring expedited review pursuant to paragraph 2 of subdivision (g) of Section 4610, the employee may request an independent medical review pursuant to Article 2.3 (commencing with Section 4615). The employee may not request appeals board resolution of

the dispute except after an independent medical review determination.

(f) A one-page independent medical review application form, as developed and approved by the division, and a preaddressed envelope, shall accompany written responses made pursuant to subdivision (b), if health services have been modified, delayed, or denied.

SEC. 10. Section 4612 is added to the Labor Code, to read:

4612. (a) (1) A pilot project is hereby authorized, for a duration of six years, under regulations to be developed and implemented by the administrative director. The purpose of the pilot project is to authorize an employer participating in the pilot project to contract with a health care organization, as defined in this section, to be the exclusive provider of all health care coverage, including, but not limited to, medical, surgical, and hospital treatment, pharmaceuticals, and rehabilitative care, for occupational and nonoccupational injuries and illnesses incurred by its employees. Health care organizations participating in the pilot project shall provide the following coverages to the employer through a policy that contains all of the following:

(A) Group health benefits.

(B) The medical, hospital, and rehabilitation benefits required under Division 1 (commencing with Section 50) and this division.

(C) Employers' liability coverage equivalent to that ordinarily provided under Part B of the employer's workers' compensation insurance policy.

(2) "Employer," as used in this subdivision, shall include a self-insured employer, group of self-insured employers, the insurer of an employer, multiemployer collectively bargained employee welfare benefit plans and welfare benefit plans sponsored by recognized exclusive bargaining agents for state employees.

(b) (1) Notwithstanding any other provision of this section, no employer that is required to bargain with an exclusive or certified bargaining agent that represents employees of the employer in accordance with state or federal employer-employee relations law for represented employees, shall contract with a health care organization for purposes of this section unless authorized to do so by mutual agreement between the exclusive or certified bargaining agent and the employer.

(2) Pilot projects covering state employees shall be approved by the state employer and approved pursuant to Part 5 (commencing with Section 22751) of Title 2 of the Government Code.

(c) For purposes of this section, "health care organization" means health care organizations certified under Section 4600.5, including health maintenance organizations licensed pursuant to the Knox-Keene Health Care Service Plan Act (Article 1 (commencing with Section 1340) of Chapter 2.2 of Division 2 of the Health and Safety Code) and certified by the administrative director as a health care organization under Section 4600.5. If the health care organization is a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act, the plan shall maintain good standing with the Department of Managed Heath Care. If the health care organization is licensed by the Department of Insurance, the plan shall maintain good standing with the Department of Insurance.

(d) (1) The maximum number of employees authorized under the pilot project statewide shall be limited by the administrative director to approximately 750,000 covered lives throughout a given calendar year, and the administrative director shall give priority to early applications over later applications. However, the administrative director shall not have exceeded his or her authority if the actual number exceeds 750,000 if the administrative director, in good faith, estimated the annual number. Applications that are not approved before the maximum number is reached shall be retained by the division and shall remain eligible for later approval if the number of covered lives declines below the limit.

(2) Employers seeking to participate in the pilot project pursuant to this section shall file with the administrative director a one page request for authorization setting forth the number of employees expected to be covered under the pilot project, and a statement of the health care organization offering workers' compensation coverage. The administrative director shall promptly approve requests, subject to the provisions of this section.

(3) Multiemployer, collectively bargained employee welfare benefit plans that operate in one or more of the designated counties, or exclusive bargaining agents for state employees that sponsor a welfare benefit plan, may implement a pilot project in

all counties in which participants are employed and covered for nonoccupational injuries and illnesses.

(4) The administrative director may encourage the following to participate in the pilot project:

(A) Employers in the business of selling groceries when employers are required to bargain with an exclusive or certified bargaining agent that represents employees of the employer in accordance with state or federal employer-employee relations law for represented employees, when the employers contracts with a health care organization for purposes of this section, and when authority to commence a pilot project has been authorized to do so by mutual agreement between the exclusive or certified bargaining agent and the employer.

(B) Local and state governments required to bargain with an exclusive or certified bargaining agent that represents employees of the employer in accordance with state or federal employer-employee relations law for represented employees, when these employees adhere to the standard set forth in subdivision (b).

(C) Hospitals and physicians.

(D) Nonprofit organizations.

(E) Policyholders of the State Compensation Insurance Fund who also provide their employees with health care coverage through a health care organization, and upon approval of the State Compensation Insurance Fund.

(e) An employer participating in the pilot project shall offer its employees a choice between the exclusive provider of health care option authorized under subdivision (a) and a traditional health benefits plan that allows employees to obtain workers' compensation treatment from a traditional workers' compensation provider. In the case of a pilot project established by a multiemployer, collectively bargained employee welfare benefit plan, or by a recognized exclusive bargaining agent for state employees that sponsors an employee welfare benefit plan for the benefit of employees, this choice may be exercised by an exclusive or certified bargaining agent that represents employees of the employer.

(f) (1) Any contract under this section shall utilize deductibles and coinsurance provisions that require the employer to pay deductibles and copayments of an employee until the employer declines to accept the claim as a workers' compensation claim.

Any payment required from an employee after the date the claim of workers' compensation is declined shall be reimbursed by the employer, plus interest at a rate to be determined by the division, if the injury that is the subject of the claim is later found to be a work-related injury.

(2) This section shall not be construed to limit the requirement under Section 4600 that an employer provide treatment reasonably required to cure or relieve the effects of an injury, nor shall this section be construed to prohibit an employee from changing to another provider of health care services during any annual open enrollment period.

(3) Payment for services for work-related injuries rendered in the pilot project shall be made on terms mutually agreeable between the health care service organization and employer.

(g) (1) Notwithstanding Section 4600, 4601, or any other provision of this article, an employee who has elected to enroll in the pilot project shall not have the option of predesignating a personal physician under Section 4600 as his or her treating physician if that personal physician is not provided by the health care organization, nor shall that employee have the option of changing to a physician not provided by the health care organization. Any presumption given to a predesignated personal physician, pursuant to subdivision (a) of Section 4062.9, of an employee in the pilot project shall be set-aside in favor of the presumption given to the independent medical review determination.

(2) An employee who is receiving medical treatment for an occupational injury under a contract authorized by this section shall have the right to be treated by a physician, chiropractor, or acupuncturist, or at a facility of his or her own choosing within a reasonable geographic area not less than 180 days from the date the injury was reported.

(h) A contract under this section shall not constitute an exemption from statutory provisions that require other nonmedical insurance coverage. Employers participating in the pilot program shall be entitled to a "merit rating modifier" applied to its premium for workers' compensation insurance coverage of no less than 10 percent. This merit rating modifier shall be determined by the Insurance Commissioner.

(i) If an employer enters into a contract under this section, the employer shall provide, by the means set forth in Section 3700, indemnity benefits to ensure that the total coverage afforded by both the contract and the policy providing indemnity benefits shall provide the total compensation required under this division.

(j) The administrative director shall, at the completion of the third year of the pilot project, and if an appropriation is made for this purpose, prepare an interim report, and by January 1, 2010, prepare a final report to the Legislature and the Governor describing the pilot project. In order to prepare the report, the administrative director shall have the authority to require each pilot program to provide information to address the following:

(1) A comparison of employer costs for occupational injuries between employees who participate in the pilot program and employees who elect not to participate.

(2) Return-to-work outcomes for employees participating in the pilot program when the occupational injury results in lost time from work.

(3) Numbers and percentages of employees in pilot worksites that enroll in the plan.

(4) Determination of employee satisfaction with the pilot program.

(5) Differentials in costs of treatment between different types of pilot programs for occupational and nonoccupational injuries and illnesses.

(6) Differentials in costs of treatment and of indemnity benefits among workplaces comparable in size, type of industry, and location, between pilot programs and non-24-hour care for occupational and nonoccupational injuries and illnesses.

(7) Differentials in costs of claims administration between pilot programs.

(8) Percentage of occupational injury claims litigated and the type of dispute giving rise to litigation.

(9) How continuing obligations for medical treatment under workers' compensation will be secured after completion of the pilot project.

(10) Whether the pilot project was successful when and if utilized by small employers.

(l) The employer's contract with the health care service plan shall include a provision to cover the cost of the medical care of

an injured employee that is required under this division after the employee leaves the contracting employer's employment.

(m) Enrollment or subscription in the pilot project may not be canceled or nonrenewed except in the following circumstances:

(1) Failure to pay the charge for that coverage if the enrollee or subscriber has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

(2) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting that fraud or deception by another.

(3) Any other good cause as is agreed upon in the contract between the plan and a group or the enrollee or subscriber.

(n) This section shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends that date.

SEC. 11. Section 4614 of the Labor Code is repealed.

~~4614. (a) (1) Notwithstanding Section 5307.1, where the employee's individual or organizational provider of health care services rendered under this division and paid on a fee-for-service basis is also the provider of health care services under contract with the employee's health benefit program, and the service or treatment provided is included within the range of benefits of the employee's health benefit program, and paid on a fee-for-service basis, the amount of payment for services provided under this division, for a work-related occurrence or illness, shall be no more than the amount that would have been paid for the same services under the health benefit plan, for a non-work-related occurrence or illness.~~

~~(2) A health care service plan that arranges for health care services to be rendered to an employee under this division under a contract, and which is also the employee's organizational provider for nonoccupational injuries and illnesses, with the exception of a nonprofit health care service plan that exclusively contracts with a medical group to provide or arrange for medical services to its enrollees in a designated geographic area, shall be paid by the employer for services rendered under this division only on a capitated basis.~~

~~(b) (1) Where the employee's individual or organizational provider of health care services rendered under this division who is not providing services under a contract is not the provider of~~

~~health care services under contract with the employee's health benefit program or where the services rendered under this division are not within the benefits provided under the employer-sponsored health benefit program, the provider shall receive payment that is no more than the average of the payment that would have been paid by five of the largest preferred provider organizations by geographic region. Physicians, as defined in Section 3209.3, shall be reimbursed at the same averaged rates, regardless of licensure, for the delivery of services under the same procedure code. This subdivision shall not apply to a health care service plan that provides its services on a capitated basis.~~

~~(2) The administrative director shall identify the regions and the five largest carriers in each region. The carriers shall provide the necessary information to the administrative director in the form and manner requested by the administrative director. The administrative director shall make this information available to the affected providers on an annual basis.~~

~~(c) Nothing in this section shall prohibit an individual or organizational health care provider from being paid fees different from those set forth in the official medical fee schedule by an employer, insurance carrier, third-party administrator on behalf of employers, or preferred provider organization representing an employer or insurance carrier provided that the administrative director has determined that the alternative negotiated rates between the organizational or individual provider and a payer, a third-party administrator on behalf of employers, or a preferred provider organization will produce greater savings in the aggregate than if each item on billings were to be charged at the scheduled rate.~~

~~(d) For the purposes of this section, ''organizational provider'' means an entity that arranges for health care services to be rendered directly by individual caregivers. An organizational provider may be a health care service plan, disability insurer, health care organization, preferred provider organization, or workers' compensation insurer arranging for care through a managed care network or on a fee-for-service basis. An individual provider is either an individual or institution that provides care directly to the injured worker.~~

SEC. 12. Section 4614.1 of the Labor Code is repealed.

~~4614.1. Notwithstanding subdivision (f) of Section 1345 of the Health and Safety Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act and certified by the administrative director pursuant to Section 4600.5 to provide health care pursuant to Section 4600.3 shall be permitted to accept payment from a self-insured employer, a group of self-insured employers, or the insurer of an employer on a fee-for-service basis for the provision of such health care as long as the health care service plan is not both the health care organization in which the employee is enrolled and the plan through which the employee receives regular health benefits.~~

SEC. 13. Article 2.3 (commencing with Section 4615) is added to Chapter 2 of Part 2 of Division 4 of the Labor Code, to read:

Article 2.3. Independent Medical Review

4615. (a) On and after July 1, 2004, for services recommended by a physician, as defined in Section 3209.3, disputed medical treatment services shall be resolved by submitting the dispute to independent medical review, if all of the following conditions are met:

(1) The injury for which medical treatment services have been requested is an accepted injury.

(2) The employee has filed an appeal with the employer or other entity pursuant to Section 4611, and the disputed decision is upheld or the issue remains unresolved after five days, or sooner in cases requiring expedited review pursuant to paragraph (2) of subdivision (g) of Section 4610.

(b) For the purposes of this section, "disputed medical treatment service" means any medical treatment service that has been modified, delayed, or denied by a decision of the employer, or any entity with which an employer contracts, based in whole or in part on a finding that the service is not medically necessary.

(c) An employee eligible to request independent medical review under this section shall file the one-page application form at the headquarters office of the division.

(d) The division shall expeditiously review requests and immediately notify the employee in writing as to whether the request for an independent medical review has been approved. In

reviewing a request for review, the division may waive the requirement that the employee participate in the utilization review process pursuant to Section 4611. When a request for independent review is not approved by the division, the division shall notify the employee of the reason for the denial and other remedies available to the employee. The sole basis for denying the request for independent review shall be that the subject matter of the dispute sought to be reviewed does not relate to the medical necessity of the medical treatment service that has been modified, delayed, or denied. The decision of the division shall be final and not subject to review by the board. Under no circumstances shall the division deny a request for review based upon its judgment as to the necessity of the medical treatment service that is the subject of the request.

(e) The employer, insurer, or other entity shall provide to the independent medical review organization designated by the division a copy of all documents necessary to conduct the independent medical review, pursuant to regulations adopted by the administrative director, within three business days of receipt of notice of the division's approval of the request by an employee for an independent medical review. The employer shall concurrently provide a copy of medical records required by this paragraph to the employee and the employee's medical provider, if authorized by the employee, and shall concurrently provide to the employee an annotated list and copies of all other documents submitted to the independent medical review organization.

(f) If there is an imminent and serious threat to the health of the employee, as specified in paragraph (2) of subdivision (g) of Section 4610, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of receipt of notice.

(g) The confidentiality of any employee medical information shall be maintained by the division and the independent medical review organization as required by applicable state and federal laws. The division and the independent review organization shall maintain the confidentiality of any information found by the administrative director to be the proprietary information of the employer.

(h) The treating physician and any other person designated by the employee to act as his or her representative may join with or

otherwise assist the employee in the independent medical review process.

(i) If disputed medical treatment services required to be submitted for independent medical review pursuant to paragraph (1) of subdivision (b) are rendered in the absence of an independent medical review determination, an insurer or self-insured employer shall only be liable for, and no lien for compensation pursuant to Section 4903 shall be allowed for except, those services determined medically necessary by an independent medical review and any additional or substitute medical treatment services approved pursuant to subdivision (c) of Section 4618.

4616. (a) By March 1, 2004, the division shall contract with one or more independent medical review organizations to conduct independent medical reviews. The independent medical review organizations shall be financially and otherwise independent of any workers' compensation insurer or third-party administrators doing business in this state. The administrative director shall establish additional requirements, including conflict-of-interest standards, that an organization shall be required to meet in order to conduct independent medical reviews. These organizations shall submit any information required by the administrative director to ensure freedom from conflict of interest and independence and integrity of the independent medical review process.

(b) The independent medical review organizations and the medical professionals selected by these organizations to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(c) An independent medical review organization shall conduct the review in accordance with any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment services and shall not include any consideration of compensability or other legal issues. In cases involving experimental or investigational therapies, three-member panels shall be assigned to conduct the review. In all other cases, the review shall be conducted by a single physician.

(d) Neither the independent medical review organization, nor any experts it designates to conduct a review, nor any officer,

director, or employee of the independent medical review organization shall have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(6) The employee or the employee's immediate family.

(7) The employee's or employer's legal representative or the legal representative's immediate family.

(e) In order to contract with the division for purposes of this section, an independent medical review organization shall meet all of the following requirements:

(1) The organization shall not be an affiliate, or parent organization or a subsidiary of, nor in any way be owned or controlled by, a workers' compensation insurer or third-party claims administrator. A board member, director, officer, or employee of the independent medical review organization shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health care service plan or a trade association of health care service plans shall not serve as a board member, director, officer, or employee of an independent medical review organization.

(2) The organization shall submit all of the following to the administrative director for approval:

(A) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(B) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(C) A description of how the independent medical review organization ensures compliance with the conflict-of-interest provisions of this section.

(3) The organization shall demonstrate to the administrative director that it has a quality assurance mechanism in place that does all of the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures that each independent medical review panel assigned pursuant to a request under Section 4615 includes at least one physician member who is experienced, and credentialed, in the treatment of occupationally caused injuries, illnesses, and related conditions.

(E) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(F) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts-of-interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall

be physicians or other appropriate medical providers who meet all of the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the injured employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer, except when training and experience with the issue under review reasonably requires the use of an out-of-state reviewer.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent medical review organization, shall have any material professional, familial, or financial affiliation with any of the following:

(A) The workers' compensation insurer, third-party claims administrator, or employer or other entity contracted to provide utilization review, or any officer, director, or management employee of any of these entities.

(B) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(C) The institution or facility at which the treatment would be provided.

(D) The development or manufacture of the treatment proposed for the employee whose condition is under review.

(E) The employee or the employee's immediate family.

(F) The employee's or employer's legal representative or the legal representative's immediate family.

(f) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records

of the employee, medical provider reports, as well as any other information submitted to the organization as authorized by the division or requested by the reviewers from any of the parties to the dispute. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (g).

(g) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and any of the following:

(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(2) Nationally recognized professional standards, including the guidelines as set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

(5) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(h) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the administrative director. If the disputed medical treatment service has not been provided and the employee's provider or the division certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the administrative director, reviews may be extended for up to three days in extraordinary circumstances or for good cause. The administrative director shall adopt regulations specifying a standardized format for, and minimum required elements of, determinations made pursuant to this section.

(i) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with subdivision (e) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(j) The independent medical review organization shall promptly serve the administrative director, the employer, the employee, and the employee's treating physician with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The determination shall be accompanied by a notice, in a form determined by the administrative director, informing the parties of their appeal rights under Section 4618. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in response to orders of the appeals board or a court. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(k) Upon a determination by the independent medical treatment review organization that the disputed medical treatment is medically necessary, the employer or other entity shall either authorize the disputed medical treatment or make appeal of the determination to the appeals board pursuant to Section 4618.

(l) An employer or other entity shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in of that conduct or the failure of the employer to promptly implement the decision shall constitute a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day that the decision is not

implemented. Administrative penalties shall be deposited in the Workers' Compensation Administrative Revolving Fund.

(m) The independent medical review record shall be admissible before the appeals board.

(n) Determinations of independent medical review organizations shall be made available by the division to the public upon request at cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy. The division shall remove the names of the parties, including, but not limited to, the employee, all medical providers, the employer, and any of the employer's employees or contractors, prior to releasing the determination.

(o) The administrative director may contract with the Department of Managed Health Care to administer the independent medical review process established by this section. The administrative director shall make public all independent medical review determinations, in such a manner as to maintain the confidentiality of the patient and provider.

4617. (a) The cost of the independent medical review shall be borne by the employer.

(b) The administrative director shall establish a reasonable reimbursement schedule for payment of independent medical reviews, including administrative costs.

4618. (a) The parties may appeal the independent medical review determination within 25 days of service of the determination pursuant to subdivision (i) of Section 4616 by filing a request for expedited hearing in the district office where the application for adjudication of claim has been filed. If no application has been filed, the application and the request for expedited hearing may be filed in any district office where venue is appropriate under Section 5501.5

(b) The admissible evidence shall be limited to reports and records of the primary treating physician, the reports and records submitted for independent medical review, the determination and analyses of the physician or physician panel performing the independent medical review, and the testimony of the employee.

(c) The independent medical review determination shall be presumed to be correct, and the presumption granted to the independent medical review determination shall overcome any presumption that might otherwise be granted to a treating

physician's determination of treatment of injuries that occurred prior to January 1, 2004. Any presumption given to a predesignated personal physician pursuant to subdivision (a) of Section 4062.9 shall be set aside in favor of the presumption given to the independent medical review determination. The presumption granted the independent medical review determination is a presumption affecting the burden of proof. The presumption granted pursuant to this section shall not be overcome by the fact that the guidelines used in the independent medical review differ from those otherwise approved under law.

4619. This article shall be operative only if the division enters into a contract to administer the independent medical review process specified under this article. Until that time, Section 11661.8 of the Insurance Code shall be operative.

SEC. 14. Section 4903 of the Labor Code is amended to read:

4903. The appeals board may determine, and allow as liens against any sum to be paid as compensation, any amount determined as ~~hereinafter~~ set forth in subdivisions (a) through (i), *inclusive*. If more than one lien is allowed, the appeals board may determine the priorities, if any, between the liens allowed. The liens ~~which~~ *that* may be allowed ~~hereunder~~ are as follows:

(a) A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. No fee for legal services shall be awarded to any representative who is not an attorney, except with respect to those claims for compensation for which an application, pursuant to Section 5501, has been filed with the appeals board on or before December 31, 1991, or for which a disclosure form, pursuant to Section 4906, has been sent to the employer, or insurer or third-party administrator, if either is known, on or before December 31, 1991.

(b) *(1)* The reasonable expense incurred by, or on behalf of, the injured employee, as provided by Article 2 (commencing with Section 4600) and, to the extent the employee is entitled to reimbursement under Section 4621, medical-legal expenses as provided by Article 2.5 (commencing with Section 4620) of Chapter 2 of Part 2.

(A) On and after July 1, 2004, no lien against any sum paid as compensation shall be allowed by the appeals board if, at the time

a declaration of readiness to proceed is filed by the lien claimant, a utilization review appeal pursuant to Section 4611, an independent medical review of disputed treatment pursuant to Section 4616, or an appeal of an independent medical review determination pursuant to Section 4618 is pending unless the appeals board, upon review of the proposed lien, determines that the proposed lien is for medical services already deemed medically necessary through any independent medical review determination upheld by the appeals board or previously made by the independent medical review organization pursuant to Section 4615 that was not appealed. The lien claimant shall certify at the time the declaration of readiness to proceed is filed that no dispute over the medical necessity of the services for which the lien is sought is pending, as set forth in clause (i) or the lien claimant shall indicate why the lien should be allowed pursuant to this section, as set forth in clause (ii), as follows:

(i) Five or more certifications by the lien claimant within one year as to the lack of a medical necessity dispute, when the disputes are later determined to have existed at the time the certifications were made, shall result in the board entering an order prohibiting the lien claimant from making further liens for disputed or denied medical services to the board for a period of time not to exceed one year.

(ii) Notwithstanding the certifications set forth in clause (i) as to the nonexistence of a medical necessity dispute, a lien claimant may file a lien for disputed medical care when the medical necessity of the care has previously been determined pursuant to a decision of the board or an independent medical review that was not appealed. If the medical services secured through five or more liens within a year are later determined by the board to not have been medically necessary, the prohibition in clause (i) shall apply.

(B) In addition to, or separate from, the prohibition set forth in clauses (i) and (ii) of subparagraph (A), the appeals board shall inform the regulatory authority of any provider providing services on a lien that the board has determined shall not apply to a claim, and request an examination of the provider or providers for possible violations of standards of professional conduct.

(2) On and after July 1, 2004, no lien against any sum paid as compensation shall be allowed by the appeals board if the lien has been filed for expenses for medical treatment when that treatment

has been denied pursuant to a utilization review that was not timely appealed, denied by an appeal of a utilization review that itself was not timely appealed to an independent medical review, denied by an independent medical review of disputed treatment pursuant to Section 4615 that was not timely appealed, or denied upon an appeal of an independent medical review decision pursuant to Section 4618.

(c) The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury.

(d) The reasonable burial expenses of the deceased employee, not to exceed the amount provided for by Section 4701.

(e) The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. These expenses shall be allowed in the proportion that the appeals board deems proper, under application of the spouse, guardian of the minor children, or the assignee, pursuant to subdivision (a) of Section 11477 of the Welfare and Institutions Code, of the spouse, a former spouse, or minor children. A collection received as a result of a lien against a workers' compensation award imposed pursuant to this subdivision for payment of child support ordered by a court shall be credited as provided in Section 695.221 of the Code of Civil Procedure.

(f) The amount of unemployment compensation disability benefits that have been paid under, or pursuant to, the Unemployment Insurance Code in those cases where, pending a determination under this division, there was uncertainty whether the benefits were payable under the Unemployment Insurance Code or payable hereunder~~; provided, however, that~~. *However,* any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(g) The amount of unemployment compensation benefits and extended duration benefits paid to the injured employee for the same day or days for which he or she receives, or is entitled to receive, temporary total disability indemnity payments under this division~~; provided, however, that~~. *However,* any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(h) The amount of indemnification granted by the California Victims of Crime Program pursuant to Article 1 (commencing

with Section 13959) of Chapter 5 of Part 4 of Division 3 of Title 2 of the Government Code.

(i) The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account pursuant to ~~the provisions of~~ Chapter 11 (commencing with Section 4401) of Part 1.

SEC. 15. Section 5304 of the Labor Code is amended to read:

5304. The appeals board has jurisdiction over any controversy relating to, or arising out of, Sections 4600 to 4605, inclusive, unless an express agreement fixing the amounts to be paid for medical, surgical, or hospital treatment, as ~~such~~ *this* treatment is described in those sections, has been made between the persons or institutions rendering ~~such~~ *that* treatment and the employer or insurer. *With respect to disputes subject to the independent medical review process specified in Article 2.3 (commencing with Section 4615) of Chapter 2 of Part 2, the jurisdiction of the appeals board shall be exercised in a manner consistent with Section 4618.*

SEC. 16. Section 5502 of the Labor Code is amended to read:

5502. (a) Except as provided in subdivisions (b) and (d), the hearing shall be held not less than 10 days, and not more than 60 days, after the date a declaration of readiness to proceed, on a form prescribed by the court administrator, is filed. If a claim form has been filed for an injury occurring on or after January 1, 1990, and before January 1, 1994, an application for adjudication shall accompany the declaration of readiness to proceed.

(b) The court administrator shall establish a priority calendar for issues requiring an expedited hearing and decision. A hearing shall be held and a determination as to the rights of the parties shall be made and filed within 30 days after the declaration of readiness to proceed is filed if the issues in dispute are any of the following:

(1) The employee's entitlement to medical treatment pursuant to Section 4600*, including appeals of independent medical review determinations, pursuant to Section 4618*.

(2) The employee's entitlement to, or the amount of, temporary disability indemnity payments.

(3) The employee's entitlement to vocational rehabilitation services, or the termination of an employer's liability to provide these services to an employee.

(4) The employee's entitlement to compensation from one or more responsible employers when two or more employers dispute liability as among themselves.

(5) Any other issues requiring an expedited hearing and determination as prescribed in rules and regulations of the administrative director.

(c) The court administrator shall establish a priority conference calendar for cases in which the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment or in the course of employment. The conference shall be conducted by a workers' compensation administrative law judge within 30 days after the declaration of readiness to proceed. If the dispute cannot be resolved at the conference, a trial shall be set as expeditiously as possible, unless good cause is shown why discovery is not complete, in which case status conferences shall be held at regular intervals. The case shall be set for trial when discovery is complete, or when the workers' compensation administrative law judge determines that the parties have had sufficient time in which to complete reasonable discovery. A determination as to the rights of the parties shall be made and filed within 30 days after the trial.

(d) The court administrator shall report quarterly to the Governor and to the Legislature concerning the frequency and types of issues which are not heard and decided within the period prescribed in this section and the reasons therefor.

(e) (1) In all cases, a mandatory settlement conference shall be conducted not less than 10 days, and not more than 30 days, after the filing of a declaration of readiness to proceed. If the dispute is not resolved, the regular hearing shall be held within 75 days after the declaration of readiness to proceed is filed.

(2) The settlement conference shall be conducted by a workers' compensation administrative law judge or by a referee who is eligible to be a workers' compensation administrative law judge or eligible to be an arbitrator under Section 5270.5. At the mandatory settlement conference, the referee or workers' compensation administrative law judge shall have the authority to resolve the dispute, including the authority to approve a compromise and release or issue a stipulated finding and award, and if the dispute cannot be resolved, to frame the issues and stipulations for trial. The appeals board shall adopt any regulations

needed to implement this subdivision. The presiding workers' compensation administrative law judge shall supervise settlement conference referees in the performance of their judicial functions under this subdivision.

(3) If the claim is not resolved at the mandatory settlement conference, the parties shall file a pretrial conference statement noting the specific issues in dispute, each party's proposed permanent disability rating, and listing the exhibits, and disclosing witnesses. Discovery shall close on the date of the mandatory settlement conference. Evidence not disclosed or obtained thereafter shall not be admissible unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference.

(f) In cases involving the Director of ~~the Department of~~ Industrial Relations in his or her capacity as administrator of the Uninsured Employers Fund, this section shall not apply unless proof of service, as specified in paragraph (1) of subdivision (d) of Section 3716 has been filed with the appeals board and provided to the Director of Industrial Relations, valid jurisdiction has been established over the employer, and the fund has been joined.

(g) Except as provided in subdivision (a) and in Section 4065, ~~the provisions of~~ this section shall apply irrespective of the date of injury.

SEC. 17. Section 5502.5 of the Labor Code is amended to read:

5502.5. *(a)* A continuance of any conference or hearing required by Section 5502 shall not be favored, but may be granted by a workers' compensation *administrative law* judge upon any terms as are just upon a showing of good cause. When determining a request for continuance, the workers' compensation *administrative law* judge shall take into consideration the complexity of the issues, the diligence of the parties, and the prejudice incurred on the part of any party by reasons of granting or denying a continuance.

(b) When a workers' compensation administrative law judge determines that an issue set for hearing cannot be decided prior to a pending independent medical review determination because a finding of entitlement to a particular medical treatment service is a precondition to entitlement to another class of compensation,

proceedings may be stayed until the issuance of a determination pursuant to Section 4616. If an appeal of the determination is filed pursuant to Section 4618, it shall be consolidated for hearing with the remaining pending issues.

SEC. 18. Section 5703 of the Labor Code is amended to read:

5703. The appeals board may receive as evidence either at or subsequent to a hearing, and use as proof of any fact in dispute, the following matters, in addition to sworn testimony presented in open hearing:

(a) Reports of attending or examining physicians.

(1) Statements concerning any bill for services are admissible only if made under penalty of perjury that they are true and correct to the best knowledge of the physician.

(2) In addition, reports are admissible under this subdivision only if the physician has further stated in the body of the report that there has not been a violation of Section 139.3 and that the contents of the report are true and correct to the best knowledge of the physician. The statement shall be made under penalty of perjury.

(b) Reports of special investigators appointed by the appeals board or a workers' compensation judge to investigate and report upon any scientific or medical question.

(c) Reports of employers, containing copies of timesheets, book accounts, reports, and other records properly authenticated.

(d) Properly authenticated copies of hospital records of the case of the injured employee.

(e) All publications of the Division of Workers' Compensation.

(f) All official publications of the State of California and United States governments.

(g) Excerpts from expert testimony received by the appeals board upon similar issues of scientific fact in other cases and the prior decisions of the appeals board upon similar issues.

(h) Determinations, analyses, and all other materials comprising the record in an independent medical review pursuant to Article 2.3 (commencing with Section 4615) of Chapter 2 of Part 2.

SEC. 19. Section 5814.3 is added to the Labor Code, to read:

5814.3. (a) Section 5814 shall not apply to payments for medical treatment that are subject to utilization review or independent medical review pursuant to Sections 4610 and 4615, when that medical treatment is appealed by an insurer to the

appeals board, pursuant to Section 4618, and the appeals board upholds the appeal.

(b) When the appeals board upholds an independent medical review determination appealed by an insurer, the board may, in addition to or independent of any increase in an award prescribed by law, and in addition to or independent of other penalties prescribed by law, order the insurer or self-insured employer to amend the utilization review used by the insurer or self-insured employer in a manner consistent with the independent medical review determination. In addition, all insurers shall conform to the order of the board within 10 days of the ruling being made public by the division. The division may impose upon an insurer that is not in conformance with the ruling, within 10 days of publication by the division, a fine not to exceed five thousand dollars ($5,000) per day and, if the violation is willful, up to one hundred thousand dollars ($100,000) in total for purposes of deterring the insurer or self-insured employer from future denials of medical treatment that is medically necessary.

SEC. 20. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~amended to read:~~

~~1871.4. (a) It is unlawful to do any of the following:~~

~~(1) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.~~

~~(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.~~

~~(3) Knowingly assist, abet, conspire with, or solicit any person in an unlawful act under this section.~~

~~(4) Make or cause to be made any knowingly false or fraudulent statements with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.~~

~~For the purposes of this subdivision, "statement" includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expense as defined in Section 4620 of the Labor Code, other evidence of loss, injury, or expense, or payment.~~

~~(5) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.~~

~~(6) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of discouraging an employer from claiming any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.~~

~~(b) Every person who violates subdivision (a) shall be punished by imprisonment in county jail for one year, or in the state prison, for two, three, or five years, or by a fine not exceeding one hundred thousand dollars ($100,000) or double the value of the fraud, whichever is greater, or by both imprisonment and fine. Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid.~~

~~(c) Any person who violates subdivision (a) and who has a prior felony conviction of that subdivision, of former Section 556, of former Section 1871.1, or of Section 548 or 550 of the Penal Code, shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (b).~~

~~The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.~~

~~(d) This section shall not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction.~~

~~SEC. 2. Section 11661.8 is added to the Insurance Code, to read:~~

~~11661.8. An insurer shall not insure an employer for more than 15 one-hour visits to a chiropractor by an employee in connection with any claim made under the policy, unless the employee has obtained the approval of a physician licensed pursuant to Section 2050 of the Business and Professions Code for additional visits.~~

~~SEC. 3. Section 11760 of the Insurance Code is amended to read:~~

~~11760. (a) It is unlawful to make or cause to be made any knowingly false or fraudulent statement, whether made orally or in writing, of any fact material to the determination of the premium, rate, or cost of any policy of workers' compensation insurance, for the purpose of reducing the premium, rate, or cost of the insurance. Any person convicted of violating this subdivision shall be punished by imprisonment in the county jail for one year, or in the state prison for two, three, or five years, or by a fine not exceeding one hundred thousand dollars ($100,000), or double the value of the fraud, whichever is greater, or by both imprisonment and fine.~~

~~(b) Any person who violates subdivision (a) and who has a prior felony conviction of the offense set forth in that subdivision shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (a). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.~~

~~SEC. 4. Section 11880 of the Insurance Code is amended to read:~~

~~11880. (a) It is unlawful to make or cause to be made any knowingly false or fraudulent statement, whether made orally or in writing, of any fact material to the determination of the premium, rate, or cost of any policy of workers' compensation~~

~~insurance issued or administered by the State Compensation Insurance Fund for the purpose of reducing the premium, rate, or cost of the insurance. Any person convicted of violating this subdivision shall be punished by imprisonment in the county jail for one year, or in the state prison for two, three, or five years, or by a fine not exceeding one hundred thousand dollars ($100,000), or double the value of the fraud, whichever is greater, or by both imprisonment and fine.~~

~~(b) Any person who violates subdivision (a) and who has a prior felony conviction of the offense set forth in that subdivision shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (a). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.~~

~~SEC. 5. Section 139.3 of the Labor Code is amended to read:~~

~~139.3. (a) Notwithstanding any other provision of law, to the extent those goods and services are paid for pursuant to Division 4 (commencing with Section 3200), it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, outpatient surgical center, or diagnostic imaging goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.~~

~~(b) For purposes of this section and Section 139.31, the following shall apply:~~

~~(1) ''Diagnostic imaging'' includes, but is not limited to, all X-ray, computed axial tomography magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.~~

~~(2) ''Immediate family'' includes the spouse and children of the physician, the parents of the physician, and the spouses of the children of the physician.~~

~~(3) ''Physician'' means a physician as defined in Section 3209.3.~~

~~(4) A ‘‘financial interest’’ includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the physician refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect relationship between a physician and the referral recipient, including, but not limited to, an arrangement whereby a physician has an ownership interest in any entity that leases property to the referral recipient. Any financial interest transferred by a physician to, or otherwise established in, any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the physician.~~

~~(5) A ‘‘physician’s office’’ is either of the following:~~

~~(A) An office of a physician in solo practice.~~

~~(B) An office in which the services or goods are personally provided by the physician or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when that licensure or certification is required by law.~~

~~(6) The ‘‘office of a group practice’’ is an office or offices in which two or more physicians are legally organized as a partnership, professional corporation, or not-for-profit corporation licensed according to subdivision (a) of Section 1204 of the Health and Safety Code for which all of the following are applicable:~~

~~(A) Each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel.~~

~~(B) Substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, and except that in the case of multispecialty clinics, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the~~

~~name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.~~

~~(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.~~

~~(7) "Outpatient surgical center" means a surgical clinic, as defined in paragraph (1) of subdivision (b) of Section 1204 of the Health and Safety Code, when the clinic renders services that are paid for pursuant to Division 4 (commencing with Section 3200).~~

~~(c) (1) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.~~

~~(2) It shall be unlawful for a physician to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation.~~

~~(d) No claim for payment shall be presented by an entity to any individual, third-party payor, or other entity for a good or service furnished pursuant to a referral prohibited under this section.~~

~~(e) A physician who refers to or seeks consultation from an organization in which the physician has a financial interest shall disclose this interest to the patient or if the patient is a minor, to the patient's parents or legal guardian in writing at the time of the referral.~~

~~(f) No insurer, self-insurer, or other payor shall pay a charge or lien for any good or service resulting from a referral in violation of this section.~~

~~(g) A violation of subdivision (a) shall be a misdemeanor. The appropriate licensing board shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), (e), or (f) is a public offense and~~

~~is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.~~

~~SEC. 6. Section 4600.2 is added to the Labor Code, to read:~~

~~4600.2. Notwithstanding Section 4600, an employer that is insured or self-insured pursuant to Section 3700 is not required to provide, and is not liable for, more than 15 one-hour visits to a chiropractor by an employee in connection with any compensable claim under this division unless the employee has obtained approval for additional visits from a physician licensed pursuant to Section 2050 of the Business and Professions Code.~~

~~SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

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